



# FLEXIBLE BENEFITS PLAN ENROLLMENT — PLAN YEAR \_\_\_\_\_

State of Tennessee • Department of Finance and Administration • Benefits Administration  
 26th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590 or 1.800.253.9981 • Fax: 615.741.8196

Complete this form only if you wish to participate in the Medical or Dependent Day Care Reimbursement Plan.

EMPLOYEE INFORMATION			
Last Name	First Name	Middle Initial	Social Security Number
Home Address	City	State	Zip Code
Department Name	Dept ID / Budget Code	Date Hired	Employee ID (if known)
Work Phone	Payroll Frequency (paychecks per year) <input type="checkbox"/> 12 <input type="checkbox"/> 24 <input type="checkbox"/> Other _____	Enrollment Status <input type="checkbox"/> Annual Enrollment <input type="checkbox"/> New Hire	

REIMBURSEMENT ACCOUNT ENROLLMENT (new elections must be filed each year)	
Indicate the amount you wish to contribute to a reimbursement account through tax-free salary reduction by completing the sections below. If you have questions, contact your personnel office for additional literature or you may call Benefits Administration at 615.741.3590 or 1.800.253.9981.	
In Box #1, indicate the reduction amount per pay period. In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year. Consult your payroll office if you are unsure of how many checks you will receive. In Box #3, indicate the total dollar amount you elect to contribute for the plan year.	
Medical Expense Reimbursement Account	Dependent Day Care Reimbursement Account
Maximum allowable annual contribution is \$7,500	<b>TAX FILING STATUS (PLEASE CHECK ONE)</b> <input type="checkbox"/> Married, filing separately (maximum \$2,500) <input type="checkbox"/> Married, filing jointly (maximum \$5,000) <input type="checkbox"/> Head of household (maximum \$5,000)
Box #1 Reduction per regular paycheck _____	Box #1 Reduction per regular paycheck _____
Box #2 Number of regular paychecks expected <b>X</b> _____	Box #2 Number of regular paychecks expected <b>X</b> _____
Box #3 Total plan year dollar amount    =    _____	Box #3 Total plan year dollar amount    =    _____

AUTHORIZATION	
<ul style="list-style-type: none"> <li>I understand this is not an application for insurance. To enroll or change my medical or dental insurance, I must complete the proper insurance forms.</li> <li>I hereby authorize my employer to reduce my gross salary before federal, state and social security taxes are calculated by the total amount of annual salary reduction indicated above. I understand that the amount of salary reduction will include the items specified above and will continue in effect unless I file an approved Family Status Change.</li> <li>I understand that any amount remaining in any Reimbursement Account that is not used during the plan year will be forfeited since it cannot be carried to the next plan year.</li> <li>I understand and agree that the state will not incur any liability resulting from either my participation in or my failure to accurately complete this enrollment form. I further understand that if I elect not to participate in salary reduction with respect to the benefits listed above, I forego my right to participate during the upcoming plan year.</li> </ul>	
Employee Signature	Date Signed

Return this application to your human resource office after making a copy for your records.

For questions regarding enrollment or a family status change, please call Benefits Administration at 615.741.3590 or 1.800.253.9981.

For questions regarding reimbursement requests, please call the Department of Treasury at 615.532.3170 or 1.877.681.0155.